No. 00-1021

NOV 7 2001

IN THE

Supreme Court of the United States

RUSH PRUDENTIAL HMO, INC.,

Petitioner,

v.

DEBRA C. MORAN AND STATE OF ILLINOIS,

Respondents.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF OF *AMICI CURIAE* TEXAS WATCH AND JACQUELINE BURROSS IN SUPPORT OF RESPONDENTS

GEORGE PARKER YOUNG
Counsel of Record
FRIEDMAN, YOUNG, SUDER & COOKE
Attorneys for Amici Curiae
Texas Watch and Jacqueline Burross
P.O. Box 2508
Fort Worth, Texas 76113
(817) 334-0400

170474

COUNSEL PRESS
(800) 274-3321 • (800) 359-6859

BEST AVAILABLE COPY

TABLE OF CONTENTS

Page

Table of Cited Authorities ii

Statement of Interest 1

Summary of the Argument 3

Argument 4

1. *Pegram v. Herdrich*: Congress did not intend for ERISA to preempt health-care issues, nor to set up a federalized system of treating medical-necessity determinations when made by an HMO. 4

2. The background and purpose of the 1973 Federal HMO Act show that Congress did not intend to remove medical-necessity issues from health-care providers—or from the states. 10

3. ERISA's own legislative history negates any congressional intent to preempt state health-care-related claims. 16

Conclusion 26

TABLE OF CITED AUTHORITIES

Page

Cases:

Bauman v. U.S. Healthcare, Inc., 193 F.3d 151 (3d Cir. 1999), *cert. denied*, 2000 U.S. Lexis 4177, 68 U.S.L.W. 3773 (June 19, 2000) 7, 8

California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc., 117 S. Ct. 832 (1997) 5, 19, 20

Corcoran v. United HealthCare, Inc., 965 F.2d 1321 (5th Cir. 1992) 7

Corporate Health Ins., Inc. v. Texas Dept. of Ins., 215 F.3d 526 (5th Cir. 2000), *reh'g denied*, 220 F.3d 641 (2000), *petition for writ of certiorari filed*, 69 U.S.L.W. 3317 (Oct. 24, 2000) .. 1, 2, 7, 13, 20

De Buono v. NYSA-ILA Med. & Clinical Servs. Fund, 117 S. Ct. 1747 (1997) 5, 19

New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995) 5, 8, 18, 19, 20, 21, 22

Pegram v. Herdrich, 530 U.S. 211, 120 S. Ct. 2143, 147 L. Ed. 2d 164 (2000) ..... *passim*

United States v. Lopez, 514 U.S. 549 (1995) 21, 22

United States v. Morrison, 520 U.S. 598, 120 S. Ct. 1740, 146 L. Ed. 2d 658 (2000) 21, 22

Cited Authorities

Page

Statutes:

Rule 420-5-6.08, Alabama State Board of Health (1999) 9

2000 Alaska Sess. Laws 99 9

ARIZ. REV. STAT. § 20-2537 (West Supp. 1999) 9

CAL. INS. CODE § 10169 (West Supp. 2000) 9

COLO. REV. STAT. § 10-16-113.5 (West 1999) 9

CONN. GEN. STAT. § 38a-478n (West Supp. 2000) .. 9

DEL. CODE ANN. tit. 16, § 9119 (2000) 9

D.C. CODE § 32-571.7 (Lexis Supp. 2000) 9

2000 Fla. Laws ch. 00-256 (West) 9

GA. CODE ANN.§ 33-20A-32 (2000) 9

2000 Haw. Sess. Laws 250 9

215 ILL. COMP. STAT. 125/4-10 (West Supp. 2000) ... 3, 9

IND. INS. CODE ANN. § 27-13-10.1-1 (West 2000) .. 9

IOWA CODE ANN. § 514J (West 2000) 9

KAN. STAT. ANN. § 40-22a13 (Supp. 1999) 9

	Page
2000 Kentucky Laws Reg. Sess. 262 (West)	9
La. Rev. Stat. Ann. § 22:3081 (2000)	9
Md. Code Ann. Ins. §§ 15-10A through 15-10B (Lexis Supp. 1999)	9
Mass. Ann. Laws ch. 111, § 217 (West 2001)	9
2000 Me. Legis. Serv. 742 (West)	9
2000 Mich. Legis. Serv. 251 (West)	9
Minn. Stat. Ann. § 62Q.73 (West Supp. 2000)	9
Mo. Rev. Stat. § 376.1385 (1997)	9
Mont. Code Ann. § 33-37-102 (1999)	9
N.C. Gen. Stat. §§ 58-50-61, 58-50-62 (1998)	9
N.H. Rev. Stat. Ann. 420-J:5 (2000)	9
N.J. Stat. Ann. §§ 26:2S-11, 26:2S-12 (West Supp. 2000)	9
N.M. Adm. Code tit. 13, § 10.17.24 (Michie Supp. 2000)	9
N.Y. Ins. Law § 4904 (McKinney 1999)	9
Ohio Rev. Code Ann. § 1751.84 (Baldwin Supp. 2000)	9

	Page
Okla. Stat. Ann. tit. 63, § 2528.3 (West 1999)	9
2001 Ore. HB 3040 (2001)	9
40 PA. Cons. Stat. § 991.2162 (1998)	9
R.I. Gen. Laws § 23-17.12-10 (Lexis Supp. 2000)	9
2000 S.C. Acts 380	9
Tenn. Code Ann. § 56-32-227 (West 1999)	9
Tex. Civ. Prac. & Rem. Code § 88.003 (2001)	9
Utah Code Ann. § 31A-22-629 (2000)	9
VA. Code § 38.2-5900 to 38.2-5905 (Michie Supp. 2000)	9
VT. Stat. Ann. tit. 8, § 4089f (1998)	9
2000 Wash. Legis. Serv. 5 (West)	9
W. Va. Code § 33-25C-6 (2001)	9
2000 Wisc. Legis. Serv. 155 (West)	9
29 U.S.C.A. §§ 1001, *et seq.*	4
29 U.S.C. § 1001(a)	17
29 U.S.C.A. § 1144	18

Page

29 U.S.C.A. § 1144(a) 2, 9

29 U.S.C.A. § 1144(b)(2)(A) 3

42 U.S.C.A. § 300e, *et seq.* 4

Other Authorities:

Employee Retirement Income Security Act of 1974,
H. REP. Nos. 93-533, 93-807
S. REP. Nos. 93-127, 93-383,
H.R. CONF. REP. No. 93-1280,
reprinted in 1974 U.S.C.C.A.N. 4639 (1974) . 1, 17, 23

Federal Health Maintenance Organization Act of 1973,
S. REP. No. 93-129,
reprinted in 1973 U.S.C.C.A.N. 3033 (1973) . 11, 12, 14

H.R. CONF. REP. No. 94-1513,
reprinted in 1976 U.S.C.C.A.N. 4355 (1976) ... 15

A. Christopher Bryant & Timothy J. Simeone, "Remanding to Congress: The Supreme Court's New "On the Record" Constitutional Review of Federal Statutes," 86 CORNELL L. REV. 328 (2001) 22, 23

Erwin Chemerinsky, "Shrinking Federal Powers," 37 TRIAL 82 (Jan. 2001) 22

Catherine L. Fisk, "The Last Article About the Language of ERISA Preemption? A Case Study in the Failure of Textualism," 33 HARV. J. ON LEGISLATION 35 (Winter 1996) 18, 19, 24

Page

Leon E. Irish & Harrison J. Cohen, "ERISA Preemption: Judicial Flexibility and Statutory Rigidity," 19 U. MICH. J.L. REF. 109 (1985) 18

Jeffrey W. Stempel & Nadia von Magdenko, "Doctors, HMOs, ERISA, and the Public Interest 36 TORT & INS. L.J. at 696 ..... 16, 17, 23

STATEMENT OF INTEREST

Amici curiae are Texas Watch and Jacqueline Burross.[1]

Texas Watch is an advocacy organization that serves to protect consumers by encouraging fair and professional treatment from insurance companies and HMOs. Both Texas Watch's constituency and the individual *amicus* are directly affected by the issues raised in the petition for writ of certiorari pertaining to the scope of ERISA preemption of the Illinois HMO Act and its independent-review provisions in that Texas has a similar statute, ERISA's preemptive effect on which may also come before this Court.[2]

Ms. Burross is an individual who, like Debra Moran, was denied treatment by her HMO on alleged "medical necessity" grounds, and was one of 695 successful independent reviews conducted in Texas since 1997.[3] Ms. Burross suffered from lymphedema in 1997 and 1998, during which time her HMO paid from her treatment. In 1998, she was discovered to have breast cancer, which resulted in the removal of her lymph nodes. Ms. Burross' lymphedema worsened. Nonetheless, her HMO began to deny coverage

1. This *amici curiae* brief filed in support of the Respondents was funded solely by the *amici* and authored entirely by counsel for the *amici*. Pursuant to this Court's Rule 37.3(a), letters of consent from all parties to the filing of this brief are being Lodged herewith.

2. *Corporate Health Ins., Inc. v. Texas Dept. of Ins.*, 215 F.3d 526 (5th Cir. 2000), *reh'g denied*, 220 F.3d 641 (2000), *petition for writ of certiorari filed*, 69 U.S.L.W. 3317 (Oct. 24, 2000) (No. 00-665). Texas Watch has also filed an *amici curiae* brief supporting the State Petitioners' application for writ of certiorari in *Corporate Health*.

3. Pursuant to the February 2001 IRO statistics available from the Texas Department of Insurance, HMOs were found to be wrong in making their medical decisions 58% of the time.

for Ms. Burross' lymphedema treatments, despite the recommendations of her oncologist.

As a result of her HMO's denial of these medically necessary treatments, and not financially capable of paying for the treatments herself, Ms. Burross filed an independent review organization ("IRO") appeal with the Texas Department of Insurance. The IRO decided in Ms. Burross' favor, and directed her HMO to provide the medically necessary treatments for her lymphedema, treatments she continues to receive on a periodic basis.

Amici support the Respondents, who seek affirmance of the Seventh Circuit's decision in *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959 (7th Cir. 2000), *cert. granted*, __ U.S. __, 150 L. Ed. 2d 749 (2001) (No. 00-1021). That court correctly held that an Illinois law requiring health-maintenance organizations to submit to independent review of medical-necessity decisions when a primary-care physician and the HMO differ in their opinions is a statute that regulates insurance, thus falling outside the preemption provision contained in section 514(a) of the Employee Retirement Income Security Act of 1974.[4]

Though the *Moran* majority did not cite this Court's recent opinion in *Pegram v. Herdrich*, 530 U.S. 211, 120 S. Ct. 2143, 147 L. Ed. 2d 164 (2000),[5] the analysis contained in *Pegram* is helpful to the broad issue of whether and to what extent a state can lawfully regulate health-care matters without running afoul of ERISA preemption. *Amici* write

4. 29 U.S.C.A. § 1144(a). The Fifth Circuit reached a contrary result in *Corporate Health*.

5. The dissent in *Moran* believed that the panel opinion was "in tension with" *Pegram* and criticized the majority for failing to cite it. 230 F.3d at 974 (Posner, J., dissenting from denial of hearing *en banc*).

principally to discuss how *Pegram* and related authority support the *Moran* court's holding that ERISA does not preempt Illinois' independent-review statute,[6] though for somewhat different reasons.

Pegram held that HMO physicians making medical-necessity decisions are *not* making either fiduciary or administrative decisions, but are engaging in "mixed decisions" identical to those made by doctors in millions of other contexts—decisions that ERISA does not preempt. Because of the way that HMOs often define what they will and will not cover, by essentially entering the realm of medical-necessity decision-making, HMOs are engaging in the practice of medicine historically regulated by the states, a result neither intended nor supported by the legislative history either of ERISA or of the Federal HMO Act.

For these reasons, *amici* support the position of Respondents Debra C. Moran and the State of Illinois. Given the importance of the independent-review provisions to consumers, *amici* believes they can assist the Court in assessing whether ERISA preempts those provisions, and urge the Court to uphold the Seventh Circuit's opinion that it does not.

SUMMARY OF THE ARGUMENT

Amici anticipate that Respondents' briefs on the merits will thoroughly analyze and support the Seventh Circuit's conclusion that the "savings clause" found in ERISA section 514(b)(2)(A) applies to the independent-review provisions of the Illinois HMO Act. *Amici* will not duplicate those anticipated arguments, but write separately to emphasize two further reasons for upholding the appellate-court opinion in *Moran*. First, this Court's opinion in *Pegram v. Herdrich*

6. 215 ILL. COMP. STAT. 125/4-10 (West Supp. 2000).

signals broad acceptance of the idea that "mixed" eligibility and treatment decisions within an HMO structure implicate only state-law concerns and not ones covered by ERISA[7]—an idea that ought logically result in a holding that Illinois' independent-review legislation is also properly the province of state rather than federal law. Second, *Pegram*'s reliance, for part of its analysis, on the Health Maintenance Organization Act of 1973[8]—a statute predating ERISA by a year—makes useful an examination of the legislative history of that Act, for considering it in tandem with ERISA's purpose and intended scope yields further support for the validity of the Illinois legislation.

ARGUMENT

1. *Pegram v. Herdrich*: Congress did not intend for ERISA to preempt health-care issues, nor to set up a federalized system of treating medical-necessity determinations when made by an HMO.

Last year the Court held that mixed treatment and eligibility decisions made by an HMO, acting through its physicians, are not fiduciary acts under ERISA. *Pegram v. Herdrich*, 530 U.S. 211, 120 S. Ct. 2143, 147 L. Ed. 2d 164 (2000). Asked to hold that an HMO physician's delaying needed medical care to save money for the HMO and increase the physician's compensation breaches ERISA's fiduciary-duty provisions, the Court unanimously said no. Though *Pegram* did not involve whether ERISA preempts state legislation creating an independent body to review concurrent and prospective medical treatment and to opine on its necessity, the Court's reasoning is nonetheless instructive, and controlling here.

---

7. Employee Retirement Income Security Act of 1974, 29 U.S.C.A. §§ 1001, *et seq.*

8. 42 U.S.C.A. § 300e, *et seq.*

Pegram is but the latest, in fact, of a line of cases in which this Court has noted that ERISA's preemptive reach was not so broad as earlier thought; beginning in 1995, the Court handed down a trilogy of cases reining in the notion that ERISA preempts any law that could be said to in any way "relate to" an employee-benefit plan. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995); *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 117 S. Ct. 832 (1997); *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 117 S. Ct. 1747 (1997). Conversely, according to *Pegram*, recognizing an ERISA fiduciary-based remedy for what is essentially a state-law medical-malpractice claim would entail a federalized standard of reasonable medical care and "raise a puzzling issue of preemption":

> On its face, federal fiduciary law applying a malpractice standard would seem to be a prescription for preemption of state malpractice law, since the new ERISA cause of action would cover the subject of a state-law malpractice claim. See 29 U.S.C. § 1144 (preempting state laws that "relate to [an] employee benefit plan"). [*Pegram*, 120 S. Ct. at 2158.]

But noting that *Travelers* "throws some cold water on the preemption theory," the Court summed up that case's core holding: "[I]n the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." *Id.*

And, importantly, the health-care issues before the Court in *Pegram* were ones found to be "inextricably mixed": administrative, coverage-type decisions (always preempted) and pure treatment decisions (the subject, most plainly, of state malpractice laws):

> It will help to keep two sorts of arguably administrative acts in mind. *Cf. Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 361 (C.A.3 1995) (discussing dual medical/administrative roles of HMOs). What we call pure "eligibility decisions" turn on the plan's coverage of a particular condition or medical procedure for its treatment. "Treatment decisions," by contrast, are choices about how to go about diagnosing and treating a patient's condition: given a patient's constellation of symptoms, what is the appropriate medical response? [*Id.* at 2153-54.]

The Court then concluded that Herdrich's complaint raised "just such mixed eligibility and treatment decisions," giving as examples

> physicians' conclusions about when to use diagnostic tests; about seeking consultations and making referrals to physicians and facilities other than [the HMO's]; about proper standards of care, the experimental character of a proposed course of treatment, the reasonableness of a certain treatment, and the emergency character of a medical condition. [*Id.* at 2155.]

Another way to phrase these types of decisions is, of course, that they are ones of "medical necessity," which are precisely what the Illinois HMO Act contemplated in establishing its independent-review scheme.

The next section of the *Pegram* decision signaled the end of ERISA preemption of mixed eligibility decisions—a category that naturally subsumes medical-necessity determinations—with Justice Souter opining that Congress "did not intend" for an HMO to be considered a fiduciary

"to the extent that it makes mixed eligibility decisions acting through its physicians. We begin with doubt that Congress would ever have thought of a mixed eligibility decision as fiduciary in nature." *Id.* Because those types of decisions are not fiduciary ones under ERISA, the Court's conclusion effectively ends ERISA preemption of state-law claims focused on an HMO's medical-necessity decisions, since they are by definition mixed eligibility ones.[9]

A finding of no fiduciary status with regard to medical-necessity decisions is tantamount to a broader finding that ERISA does not preempt other types of claims arising from such decisions (a question the Court has not faced until now): *Pegram*'s holding and reasoning, especially when coupled with this Court's recently developed and consistent view that Congress did not intend ERISA to preempt a subject of traditional state regulation such as health care, lead logically to just such a result.[10] Here, the Illinois legislation does

9. *Pegram* would also seem to implicitly disapprove the Fifth Circuit's earlier decision in *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir. 1992), which held just such "mixed" decisions to be preempted. On petition for rehearing in *Corporate Health*, the Fifth Circuit rejected that view. 220 F.3d 641, 643-44 (5th Cir. 2000) ("[W]e do not read *Pegram* to entail that every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment, and *Corcoran* held otherwise." (Footnotes omitted.)).

10. Too, just one week after deciding *Pegram*, this Court denied an HMO's petition for writ of certiorari in *Bauman v. U.S. Healthcare, Inc.*, 193 F.3d 151 (3d Cir. 1999), *cert. denied*, 2000 U.S. Lexis 4177, 68 U.S.L.W. 3773 (June 19, 2000). In *Bauman*, the Third Circuit held that ERISA did not completely preempt the plaintiffs' claims that their HMO's failure to approve an in-home pediatric nurse visit led to their newborn daughter's death from an undiagnosed and untreated strep infection. "[I]t is the HMO's essentially medical determination of the appropriate level of care that the Baumans claim

(Cont'd)

nothing more than regulate the *quality* of medical care—the practice of medicine—by providing a mechanism for plan participants to obtain a medical "second opinion" about whether a particular course of treatment is indeed medically necessary. Because it implicates, at most, a mixed treatment issue, that legislation falls squarely within the ambit that Congress—and this Court—recognize as being reserved to the states.

The *Pegram* Court made it clear that mixed decisions are nothing more than medical-treatment decisions made "millions of times every day"[11] in other contexts, and that the decisions in those contexts are subject to state law. The most plausible conclusion to draw from *Pegram* is that even when an HMO arrogates to itself the "medical necessity" second-guessing function by the way that it writes its coverage agreement, the medical-necessity analysis by the HMO's medical director would not trigger preemption—and state law continues its vital role in regulating the HMO's health-care treatment decisions.

In short, given the development in caselaw from *Travelers* through *Pegram*, and the evolving refinements to preemption issues that this Court's decisions represent, the Seventh Circuit correctly held that ERISA does not preempt the independent-review feature of the Illinois HMO Act (though its holding was based on the savings clause rather

(Cont'd)
contributed to the death of their daughter. . . . Accordingly, the claim fits squarely within a class of claims that we identified in *Dukes* as involving the quality of care [and thus not preempted]." 193 F.3d at 163. Apparently rejecting the HMO's argument that the Baumans sought to recover for a denial of benefits—normally a preempted claim—this Court's denial of the petition for writ of certiorari shows that *Pegram*'s holding and reasoning are not limited to the narrow question of fiduciary status for a malfeasant HMO.

11. 120 S. Ct. at 2156.

than a finding that the legislation fell outside section 514(a)'s "relates to" language). And because at least forty-two states and the District of Columbia have either legislation or regulations establishing similar independent-review procedures, this is an issue of national importance.[12]

12. Rule 420-5-6.08, Alabama State Board of Health (1999); 2000 Alaska Sess. Laws 99; ARIZ. REV. STAT. § 20-2537 (West Supp. 1999); CAL. INS. CODE § 10169 (West Supp. 2000); COLO. REV. STAT. § 10-16-113.5 (West 1999); CONN. GEN. STAT. § 38a-478n (West Supp. 2000); DEL. CODE ANN. tit. 16, § 9119 (2000); D.C. CODE § 32-571.7 (Lexis Supp. 2000); 2000 Fla. Laws ch. 00-256 (West); GA. CODE ANN.§ 33-20A-32 (2000); 2000 Haw. Sess. Laws 250; 215 ILL. COMP. STAT. 125/4-10 (West Supp. 2000); IND. INS. CODE ANN. § 27-13-10.1-1 (West 2000); IOWA CODE ANN. § 514J (West 2000); KAN. STAT. ANN. § 40-22a13 (Supp. 1999); 2000 Kentucky Laws Reg. Sess. 262 (West); LA. REV. STAT. ANN. § 22:3081 (2000); 2000 Me. Legis. Serv. 742 (West); MD. CODE ANN. INS. §§ 15-10A through 15-10B (Lexis Supp. 1999); MASS. ANN. LAWS ch. 111, § 217 (West 2001); 2000 Mich. Legis. Serv. 251 (West); MINN. STAT. ANN. § 62Q.73 (West Supp. 2000); MO. REV. STAT. § 376.1385 (1997); MONT. CODE ANN. § 33-37-102 (1999); N.H. REV. STAT. ANN. 420-J:5 (2000); N.J. STAT. ANN. §§ 26:2S-11, 26:2S-12 (West Supp. 2000); N.M. ADM. CODE tit. 13, § 10.17.24 (Michie Supp. 2000); N.Y. INS. LAW § 4904 (McKinney 1999); N.C. GEN. STAT. §§ 58-50-61, 58-50-62 (1998); OHIO REV. CODE ANN. § 1751.84 (Baldwin Supp. 2000); OKLA. STAT. ANN. tit. 63, § 2528.3 (West 1999); 2001 Ore. HB 3040 (2001); 40 PA. CONS. STAT. § 991.2162 (1998); R.I. GEN. LAWS § 23-17.12-10 (Lexis Supp. 2000); 2000 S.C. Acts 380; TENN. CODE ANN. § 56-32-227 (West 1999); TEX. CIV. PRAC. & REM. CODE § 88.003 (2001); UTAH CODE ANN. § 31A-22-629 (2000); VT. STAT. ANN. tit. 8, § 4089f (1998); VA. CODE § 38.2-5900 to 38.2-5905 (Michie Supp. 2000); 2000 Wash. Legis. Serv. 5 (West); W. VA. CODE § 33-25C-6 (2001); 2000 Wisc. Legis. Serv. 155 (West).

2. The background and purpose of the 1973 Federal HMO Act show that Congress did not intend to remove medical-necessity issues from health-care providers—or from the states.

In addition to the aspects of *Pegram* discussed above, the Court also made explicit the usefulness of considering Congress's enactment of the Health Maintenance Organization Act of 1973 just one year before it enacted ERISA: in the Court's view, Congress could hardly have meant to encourage the formation of HMOs only to stifle them a year later by (if Herdrich's interpretation were accepted) including a fiduciary-duty standard in ERISA whose enforcement would entail "nothing less than elimination of the for-profit HMO." *Pegram*, 120 S. Ct. at 2156.[13]

While debate could be had on this latter conclusion (a debate not called for here), the pertinent point for the instant case is this: when considering whether Congress meant for ERISA to preempt state-law quality-of-care/ medical-necessity regulation of HMOs, such as Illinois' independent-review provisions, examining the preceding year's Federal HMO Act's legislative history is just as useful as examining that of ERISA itself. To *amici*'s knowledge, no case to date has done so, thus presenting the Court with

13. The *Pegram* Court noted that

> "for over 27 years the Congress of the United States has promoted the formation of HMO practices" and that federal courts would be "acting contrary to the congressional policy of allowing HMO organizations if it were to entertain an ERISA fiduciary claim portending wholesale attacks on existing HMOs solely because of their structure, untethered to claims of concrete harm."

120 S. Ct. at 2156-57.

an opportunity to delve more deeply into just how the two acts should be interpreted in tandem for preemption purposes.

Analysis of the Federal HMO Act—principally its 1973 legislative history and that of later specific amendments—shows that Congress intended the *states* to regulate HMO quality, including medical-necessity determinations, and never contemplated that HMOs would be able to arrogate to themselves the practice of medicine through a statute (ERISA) requiring almost unquestioning deference to a plan administrator's "benefit" decision. Stated another way, there is no demonstrable congressional intent to create, or even to show cognizance of, a process whereby *health plans* take from treating doctors, and the states, the determination of what care is appropriate, *i.e.*, medically necessary.

Several portions of the legislative history support *amici*'s view:

First, though Congress explored implementing a comprehensive federal regulation of HMO quality through a Commission on Quality Health Care Assurance,[14] it ultimately decided *not* to create such a commission, instead leaving quality-of-care regulation to the states.

But even when Congress was seriously contemplating regulating and overseeing HMO quality of care at the federal level, it recognized that some oversight and control by the states was appropriate. For example, in a separate section of the Senate Report, entitled "State Standards," the Committee on Labor and Public Welfare discussed the proposed Commission on Quality Health Care Assurance, making clear

14. Much of the 1973 Senate Report dealt with the proposed commission, but the actual HMO Act dropped it altogether when finally enacted. *See* S. REP. No. 93-129 (1973), *reprinted in* 1973 U.S.C.C.A.N. 3033.

that local (*i.e.*, state) concerns would govern health-care standards applicable to HMOs:

> [The Committee] is of the opinion that *the states*, through a designated state agency, *should be given the opportunity to develop health care standards* so that local and other variations can be taken into account though the Commission would have to assure itself that such standards would at least be as effective and rigorous as those the Commission itself would otherwise institute. The Commission is aware, for instance, that disease patterns and treatment methodologies do differ, and appropriately so, from state to state.[15]

And in the following paragraph, the Senate Committee stated:

> An added factor in this Committee's decision to *encourage states* to *develop their own standards* is the fact that experience in the medical care field has indicated that the closer the responsibility for standard development of health care regulation is to the actual provider of the care, the more likely the provider is to become involved in the development and setting of standards. The result is that these providers are more responsive to these standards when they have assisted in the development of the standards.[16]

As the Federal HMO Act was initially conceived, the Committee thus envisioned that each state should be given the opportunity to enforce its own promulgated HMO-quality

15. *Id.* at 3077 (emphasis added).

16. *Id.* (emphasis added).

standards, and nothing in the subsequent Conference Report or floor debate negates this clear congressional intent that (a) treating medical professionals, not HMOs, would determine "medical necessity"; and (b) the states would be responsible for administering HMO quality standards for health care, including "medical necessity."[17] And since Congress ultimately rejected establishing a federal commission that would have, to some extent, usurped state control, its intent is clear: quality-of-care issues—including those of medical necessity—were best left *entirely* to state control and regulation.

Elsewhere in the Senate Reports for the 1973 Act, it is apparent that the Committee on Labor and Public Welfare considered that the HMO structure would actually *remove* any financial incentives from the practice of medicine at the physician level, thereby—again—leaving medical-necessity determinations to the actual health-care providers and also, by logical extension, to the states, which were implicitly

17. It is on this point that *Corporate Health*'s inconsistency with respect to the state's right to regulate medical necessity decisions is revealed. On one hand, the Fifth Circuit states that a state licensing agency can enforce sanctions against a physician who acts on behalf of an HMO—for example, as medical director, in making medical necessity decisions. At the same time, however, the Court takes the inconsistent position that the state cannot regulate the very same decision-making in other contexts. *Corporate Health*, 215 F.3d at 534-35. This inconsistency fails to recognize and apply this Court's holding in *Pegram* which specifically states that HMO physicians making medical necessity decisions are *not* making ERISA administrative decisions, but are making just the sorts of "mixed medical decisions" made by "licensed medical practitioners millions of times every day, in every possible medical setting." *Pegram*, 120 S. Ct. at 2155-56. As a result, it is clear that the states have the right to create statutes, such as the IRO provisions at issue in both the *Moran* and *Corporate Health* matters, to ensure that these state quality-of-care standards are met by the HMO physicians who make medical necessity decisions.

(in the Act as enacted) given sole authority to regulate the field of health care:

> The medical group approach also provides opportunity for a restructuring of financial incentives. A health professional's income is not related directly to the number of services he provides, thereby removing a major incentive for over-utilization of services. In addition, it allows the *health professionals* to make judgments *based on medical necessity alone*.[18]

This language has never received substantial attention, especially in analyzing the interplay between the Federal HMO Act and ERISA, passed the very next year by the same Congress.[19] Though *Pegram* recognized the importance of the two acts adopted one year apart, that opinion did not explore the aforementioned actual legislative history. When that is done, it becomes inconceivable that with the Federal HMO Act Congress (a) meant to facilitate the removal of any financial incentives affecting medical-necessity determinations and to encourage "health professionals" and not HMOs to "make judgments based upon medical necessity alone," but (b) with ERISA, the very next year, it somehow intended to bestow on employee benefit plans, or on HMO providers contracting with ERISA plans, the ability to circumvent the prior year's intent that "*health professionals* [would make] judgments based on *medical necessity alone*." This conclusion is bolstered considerably by Congress's decision to leave all quality-of-care issues—including ones of medical necessity—to state control.

18. *Id.* at 3047 (emphasis added).

19. The Federal HMO Act and ERISA were passed during the first and second sessions, respectively, of the 93rd Congress.

Also noteworthy is that proposed section 1311(A) of the Federal HMO Act would have permitted a state agency or court to assert its jurisdiction under state law over any "health issue" not affected by standards or criteria promulgated under § 1302 of the Act.[20] The absence of any manifested intent even here to preempt state-law quality-of-care standards, and the eventual adoption of an Act that allows total state-law enforcement of health-care standards, effectively negates any argument that the Federal HMO Act began an attempt by Congress to allow federal preemption under the guise of either the HMO Act or ERISA, one year later, of state-law medical-necessity regulation.

And in the 1976 legislative session, just two years after enacting ERISA, Congress considered but rejected a federal-court remedy for enrollees of an HMO who were given assurances by an HMO, directly or indirectly, about basic and supplemental health services.[21] The conference substitute noted that rejecting the Senate's proposed federal remedy "[did] not change any existing right of individuals to bring suit in state courts."[22] This legislative history indicates that Congress did not intend to preempt even state-law fraud claims against HMOs, an intent evinced a mere two years after it enacted ERISA.

At bottom, it makes no sense to suppose that just one year after adopting the Federal HMO Act—which deliberately left regulation of HMO medical necessity decisions to the states—Congress intended through ERISA to supplant the

20. Section 1302 set forth the proposed functions of the (ultimately jettisoned) Commission.

21. H.R. Conf. Rep. No. 94-1513 (1976), *reprinted in* 1976 U.S.C.C.A.N. 4355, 4366.

22. *Id.*

states' ability to regulate the quality of medical necessity decisions that HMOs make. And nothing in ERISA's later development indicates any congressional intent, at any time, to override the clear intent contained in the HMO Act: that the states would be the ones to adopt and enforce HMO medical-care/health-care regulation.

Viewed in this light, the Illinois legislation simply fulfills what Congress envisioned when it decided to encourage the limited formation of HMOs some 27 years ago. What Congress gave the states with one hand—the ability to settle on appropriate quality-of-care standards—it did not take away with the other. As Justice Souter signaled in *Pegram*, it is wholly appropriate to consider the HMO Act when analyzing ERISA's preemptive effects on state laws that seek to establish the level of quality medical care that an HMO must provide. It would add considerably to the extant body of ERISA caselaw if this Court were to expound on the interplay between the two acts, especially given the large number of states that have enacted laws similar to the Illinois HMO Act.

3. ERISA's own legislative history negates any congressional intent to preempt state health-care-related claims.

Even without the Federal HMO Act's expressed preference for health-care/medical standards to be left up to the states, ERISA itself evinces no congressional intent to leave employees without any effective remedy for bad health-care-treatment or medical-necessity decisions. Indeed, quite the contrary.

First, the primary thrust of ERISA's protections involved *pension* plans.[23] This Court recognized that fact in *Pegram*,

23. *See, e.g.*, Jeffrey W. Stempel & Nadia von Magdenko, "Doctors, HMOs, ERISA, and the Public Interest after *Pegram v. Herdrich*," 36 TORT & INS. L.J. 687, 696 (Spring 2001) (hereafter "Stempel & Magdenko"), *quoting* 29 U.S.C. § 1001(a) itself, in which Congress declared that

> . . . despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable . . . that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

Stempel and Magdenko also note that "[a]lthough ERISA contains substantial codification of congressional findings regarding retirement benefits, the statute and legislative history are almost completely silent on the intent of Congress regarding other employer-provided fringe benefits." *Id.* at 697.

24. 530 U.S. at 232, 120 S. Ct. at 2156 (*citing* S. REP. No. 93-127, p. 5 (1973); S. REP. No. 93-383, p. 17 (1973); *id.* at 95)).

25. *Id.*

stating that congressional emphasis in drafting ERISA was on "fiduciaries' financial decisions, focusing on pension plans, the difficulty many retirees faced in getting the payments they expected, and the financial mismanagement that had too often deprived employees of their benefits."[24] As a result, according to *Pegram*, "it is at least questionable whether Congress would have had mixed eligibility decisions in mind when it provided that decisions administering a plan were fiduciary in nature."[25]

Beyond that, however, is the problem that ERISA's preemption clause was a last-minute addition to the legislation—and an addition not very well thought out at that.[26] As one commentator has noted, one of the few things that is clear about section 514's intent is that "to the extent Congress thought at all about preemption, 'section 514(a) was more in the nature of a quick statement of general principle than a workable, final rule.' "[27] As a result, "neither before nor after enactment of ERISA did Congress . . . view preemption policy issues as settled in the way that the sweeping statutory language of section 514 might suggest."[28]

That courts have consistently misinterpreted section 514—at least until the literalist tide turned with *Travelers*—is further shown when the final version of section 514, enacted with little comment, is compared with the versions originally proposed:

> As the Supreme Court has recognized, the versions of ERISA that worked their way through most of the legislative process tied the scope of preemption to the scope of ERISA regulation.

26. Catherine L. Fisk, "The Last Article About the Language of ERISA Preemption? A Case Study in the Failure of Textualism," 33 HARV. J. ON LEGISLATION 35, 53 (Winter 1996) (hereafter "Fisk") ("Although the legislative history of ERISA is voluminous [footnote omitted], it reveals that Congress gave little thought to preemption. Careful scholarship on the history of section 514 has shown that the exceptionally broad language 'was not a deeply considered result of the years of planning, negotiating, and drafting' that Congress put into ERISA [footnote omitted].")

27. Fisk at 55 (*quoting* Leon E. Irish & Harrison J. Cohen, "ERISA Preemption: Judicial Flexibility and Statutory Rigidity," 19 U. MICH. J.L. REF. 109, 114 (1985) ("Irish & Cohen")).

28. Irish & Cohen at 116.

[Footnote omitted] The House bill would have preempted state laws that "relate to the reporting and disclosure responsibilities and fiduciary responsibilities of persons acting on behalf of" ERISA-covered plans, and state laws that "relate to" funding and benefits-vesting provisions of pension plans. [Footnote omitted] The Senate version would have preempted state laws that "relate to the subject matters regulated by this Act." [Footnote omitted]

In the final joint conference on the bills, the Conference Committee abandoned these approaches and adopted the present language. When the Conference Committee Report was made available to the full Congress only ten days before the bill was enacted, little was said about the change. [Footnote omitted][29]

As Professor Fisk concludes, "[t]he change to section 514 is simply not evidence that Congress intended the enormously broad preemption, especially of laws remote from ERISA's purposes, that courts have created."[30]

And among those "remote" laws is of course state law dealing with the regulation of health care, as this Court has more than once pointed out.[31] Closely tied to such a "health care" exemption from ERISA's preemptive scope is the uselessness of "relate to" as a standard for preemption:

- "[A]pplying the 'relate to' provision according to its terms was a project doomed to failure, since, as

29. Fisk at 53.

30. *Id.* at 55.

31. *Dillingham*, 519 U.S. at 330; *De Buono*, 520 U.S. at 814; *Travelers*, 514 U.S. at 661.

many a curbstone philosopher has observed, everything is related to everything else. . . . The statutory text provides an illusory test, unless the Court is willing to decree a degree of pre-emption that no sensible person could have intended—which it is not."[32]

- Section 514's literal text could not be read to "extend to the furthest stretch of its indeterminacy, [or] for all practical purposes preemption would never run its course, for '[r]eally, universally, relations stop nowhere. . . .'"[33]

- "Our prior attempt to construe the phrase 'relate to' does not give us much help drawing the line here"; instead, the Court determined that it "must go beyond the unhelpful text . . . and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive."[34]

- "[T]his return [under the trilogy, to a traditional analysis of preemption] has included the observation that a broader reading of 'relates to' would sweep away common state action with indirect economic effects on the costs of health care plans, such as quality standards which may vary from state to state."[35]

32. *Dillingham*, 519 U.S. at 335-36 (Scalia, J., concurring).

33. *Travelers*, 514 U.S. at 655.

34. *Id.*

35. *Corporate Health*, 215 F.3d at 533. Notably, in his dissenting opinion Judge Posner focuses on the increased costs for ERISA plans (Cont'd)

To sum up, for the first two decades or so of ERISA's existence, courts applied an uncompromising analysis of preemption based on a literal reading of the text. But as both scholarship and recent caselaw has made clear, such a reading is unwarranted in light of ERISA's purpose and legislative history.

This conclusion is further warranted when this Court's recent and heightened scrutiny of congressional acts for some "national" importance is considered. For example, the Court invalidated the Gun-Free School Zones Act of 1990 in *United States v. Lopez*,[36] finding that Congress exceeded its authority under the Commerce Clause by criminalizing the possession of guns on school grounds: the Act neither regulated a commercial activity, nor did it contain a jurisdictional requirement that a particular instance of gun possession be linked to interstate commerce.

Most recently, the Court struck down the Violence Against Women Act,[37] holding that despite detailed findings

(Cont'd)
in offering health plans resulting from such independent review procedures. *Moran*, 230 F.3d at 973-74. As this Court held in *Travelers*, however,

> [T]o read the preemption provision as displacing all state laws affecting costs and charges on the theory that they indirectly relate to ERISA plans that purchase insurance policies or HMO memberships that would cover such services, would effectively read the limiting language in § 514(a) out of the statute, a conclusion that would violate basic principles of statutory interpretation.

Travelers, 514 U.S. at 661.

36. 514 U.S. 549 (1995).

37. *United States v. Morrison*, 529 U.S. 598, 120 S. Ct. 1740, 146 L. Ed. 2d 658 (2000).

in the congressional record about the economic impact of violence against women, the link between what has traditionally been a local concern and some effect on interstate commerce was too remote. In a passage reminiscent of its criticism of ERISA's "relate to" language,[38] the Court opined that Congress was relying on a "but-for casual chain from the initial occurrence of violent crime . . . to every attenuated effect upon interstate commerce."[39] Notably, the Court further observed that "[i]f accepted, [the Act's defenders'] reasoning would allow Congress to regulate any crime as long as the nationwide aggregated impact of that crime has substantial effects on employment, production, transit, or consumption."[40]

Although both *Lopez* and *Morrison* involved federal criminal statutes, the effect of this "new federalism" has not gone unnoticed.[41] And one point bears noting in light of the

38. *E.g., Travelers*, 514 U.S. at 655 ("[O]ne might be excused for wondering, at first blush, whether the words of limitation ('insofar as they . . . relate') do much limiting. If 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for '[r]eally, universally, relations stop nowhere,' H. James, Roderick Hudson xli (New York ed., World's Classics 1980).").

39. *Morrison*, 120 S. Ct. at 1752.

40. *Id.* at 1752-53.

41. *See, e.g.*, Erwin Chemerinsky, "Shrinking Federal Powers," 37 TRIAL 82, 83 (Jan. 2001) ("Many federal laws—for example, those adopted by Congress under the Commerce Clause—are sure to be objected to based on the narrow definition of Congress's power in *Morrison* and *Lopez*. . . . How far the Supreme Court will go in limiting congress's powers is uncertain. But it is clear from *Morrison* that five justices are committed to enforcing their vision of federalism and limiting the scope of federal authority."); A. Christopher Bryant (Cont'd)

Court's skepticism concerning even the most laudable congressional intent: Courts holding that ERISA preempts a claim against an HMO often rely on Congress's intent to create a uniform set of standards applicable to ERISA-related entities, thus (theoretically) avoiding the vagaries of fifty different sets of state laws. But "[d]espite the preemption language later in the statute [footnote omitted], ERISA's language and legislative history stress substantive remedies for workers more than the need for uniformity."[42] Notably, "[w]here uniformity is discussed, the implication is that uniformity and protection against state regulation are desired to prevent dilution of retirement benefits."[43] That "[n]o mention occurs of the possibility of preempting large blocks of state common law" is "unsurprising" given the statute's overall goal of protecting workers, and primarily their retirement benefits at that.[44]

(Cont'd)
& Timothy J. Simeone, "Remanding to Congress: The Supreme Court's New "On the Record" Constitutional Review of Federal Statutes," 86 CORNELL L. REV. 328, 395 (2001) ("In a series of recent cases, the Supreme Court has become increasingly aggressive in striking down federal statutes because Congress's formal legislative record inadequately supports factual findings or predictions underlying congressional action. In so doing, the Court has placed new procedural burdens on Congress to compile an extensive legislative record in support of statutes approaching the boundaries of the legislature's constitutional authority, much as federal agencies are required to compile a record in support of administrative action.")

42. Stempel & Magdenko, 36 TORT & INS. L.J. at 696.

43. *Id.* at 696-97.

44. *Id.* at 697 (*citing* H. REP. NOS. 93-533 and 93-807 (1973); SEN. REP. NOS. 93-127 and 93-383 (1973); H.R. CONF. REP. NO. 93-1280, *reprinted in* 1974 U.S.C.C.A.N. 4639 (1974); and numerous cases).

The illogic of making "uniformity" the sine qua non of ERISA preemption in the case of employee-welfare benefits as opposed to pension benefits is further shown by the fact that ERISA does not set out detailed requirements for the former, as it does with the latter. Sweeping preemption of state law makes more sense when Congress decides to regulate a field extensively, as it did with regard to pensions, but "broad preemption makes little sense when Congress does *not* extensively regulate in an area, as is the case with nonpension [e.g., health-care-related] benefits."[45]

In short, where no federal regulatory standards appear in ERISA, *and* where the HMO Act expressly left those standards to the states, preemption does nothing more than cast HMO members into a statutory abyss if legislation regulating medical-necessity decisions is found preempted.

At bottom, "uniformity" means nothing when ERISA says nothing about how patients' claims against their HMOs are to be handled—and the solution is not a blind adherence to a phantom notion of uniformity, but rather a recognition that Congress meant, as this Court has recognized, to allow states to continue their traditional role as the entity regulating the delivery of health care. Too, there are over one thousand HMOs operating in the United States, each with its own definition of "medical necessity." Were Congress as concerned about uniformity in the health-care field as some courts have opined, one would expect ERISA, or more appropriately the Federal HMO Act, to contain a uniform definition of when something is medically necessary. Neither act, of course, does.

---

45. Fisk, 33 HARV. J. LEG. at 56 (emphasis added) ("There is no evidence that Congress realized that broad preemption of state law would create a large regulatory vacuum with regard to nonpension benefits in particular. . . .").

Further, in practice the contrary view results in the *opposite* of uniformity: instead of a state (or even federal) standard of medical necessity, each HMO provides its own subjective determination of medical necessity for each given course of treatment, the result being that how a particular patient's condition is treated depends on the vagaries of which HMO he or she happens to be a member of—hardly a situation in which "uniformity" flourishes. The effect of ERISA preemption, therefore, is to subject employers and employees to over 1000 different standards of medical necessity (*i.e.*, the various managed care entities) compounded by thousands (*i.e.* the various medical directors, care managers and other employees') of standards of medical care, rather than one state standard.

If, then, Congress meant to invest ERISA with some uniform principles concerning medical necessity, thus justifying wholesale preemption of state health-care law, it failed miserably. Using "uniformity" as a means of rationalizing preemption is simply unworkable.

CONCLUSION

This case presents an important issue: Can a state lawfully adopt legislation ensuring that its citizens get medically necessary care from an HMO operating within that state's borders? Based on this Court's *Pegram* decision; on the legislative history of the 1973 HMO Act; and on ERISA's own legislative history, the answer is plainly yes. *Amici* respectfully urge this Court not only to affirm the Seventh Circuit's judgment for the reasons stated in *Moran*, but also to make clear that state independent-review legislation regulating HMOs' medical-necessity decisions do not even "relate to" ERISA plans in the first instance.

Respectfully submitted,

GEORGE PARKER YOUNG
Counsel of Record
FRIEDMAN, YOUNG, SUDER & COOKE
Attorneys for Amici Curiae
Texas Watch and Jacqueline Burross
P.O. Box 2508
Fort Worth, Texas 76113
(817) 334-0400